



General

Guideline Title

Common mental health disorders. Identification and pathways to care.

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Common mental health disorders. Identification and pathways to care. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. 61 p. (Clinical guideline; no. 123).

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Improving Access to Services

Primary and secondary care clinicians, managers, and commissioners should collaborate to develop local care pathways that promote access to services for people with common mental health disorders by:

- Supporting the integrated delivery of services across primary and secondary care
- Having clear and explicit criteria for entry to the service
- Focusing on entry and not exclusion criteria
- Having multiple means (including self-referral) to access the service
- Providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located

Provide information about the services and interventions that constitute the local care pathway, including the:

- Range and nature of the interventions provided
- Settings in which services are delivered
- Processes by which a person moves through the pathway
- Means by which progress and outcomes are assessed
- Delivery of care in related health and social care services

When providing information about local care pathways to people with common mental health disorders and their families and carers, all healthcare professionals should:

- Take into account the person's knowledge and understanding of mental health disorders and their treatment
- Ensure that such information is appropriate to the communities using the pathway

Provide all information about services in a range of languages and formats (visual, verbal, and aural) and ensure that it is available from a range of settings throughout the whole community to which the service is responsible.

Primary and secondary care clinicians, managers, and commissioners should collaborate to develop local care pathways that promote access to services for people with common mental health disorders from a range of socially excluded groups including:

- Black and minority ethnic groups
- Older people
- Those in prison or in contact with the criminal justice system
- Ex-service personnel

Support access to services and increase the uptake of interventions by:

- Ensuring systems are in place to provide for the overall coordination and continuity of care of people with common mental health disorders
- Designating a healthcare professional to oversee the whole period of care (usually a general practitioner [GP] in primary care settings)

Support access to services and increase the uptake of interventions by providing services for people with common mental health disorders in a variety of settings. Use an assessment of local needs as a basis for the structure and distribution of services, which should typically include delivery of:

- Assessment and interventions outside normal working hours
- Interventions in the person's home or other residential settings
- Specialist assessment and interventions in non-traditional community-based settings (for example, community centres and social centres) and where appropriate, in conjunction with staff from those settings
- Both generalist and specialist assessment and intervention services in primary care settings

Primary and secondary care clinicians, managers, and commissioners should consider a range of support services to facilitate access and uptake of services. These may include providing:

- Crèche facilities
- Assistance with travel
- Advocacy services

Consider modifications to the method and mode of delivery of assessment and treatment interventions and outcome monitoring (based on an assessment of local needs), which may typically include using:

- Technology (for example, text messages, email, telephone, and computers) for people who may find it difficult to, or choose not to, attend a specific service
- Bilingual therapists or independent translators

Be respectful of, and sensitive to, diverse cultural, ethnic, and religious backgrounds when working with people with common mental health disorders, and be aware of the possible variations in the presentation of these conditions. Ensure competence in:

- Culturally sensitive assessment
- Using different explanatory models of common mental health disorders
- Addressing cultural and ethnic differences when developing and implementing treatment plans
- Working with families from diverse ethnic and cultural backgrounds (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

Do not significantly vary the content and structure of assessments or interventions to address specific cultural or ethnic factors (beyond language and the cultural competence of staff), except as part of a formal evaluation of such modifications to an established intervention, as there is little evidence to support significant variations to the content and structure of assessments or interventions.

Stepped Care

A stepped-care model (see Figure 1 in the original guideline document) is used to organise the provision of services and to help people with common mental health disorders, their families, carers, and healthcare professionals to choose the most effective interventions. The model presents an integrated overview of the key assessment and treatment interventions from this guideline. Recommendations focused solely on specialist mental health services are not included (these can be found in related guidance). A recommendation in 'Developing Local Care Pathways', below, sets out the components of a stepped-care model of service delivery, which should be included in the design of local care pathways for people with common mental health disorders.

Step 1: Identification and Assessment

Identification

Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression, or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed, or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

If a person answers 'yes' to either of the above questions consider depression and follow the recommendations for Assessment below (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder, or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see Appendix D in the original guideline document).

- If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see "Assessment" below).
- If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and follow the recommendations for assessment (see "Assessment" below).

For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer* and/or asking a family member or carer about the person's symptoms to identify a possible common mental health disorder. If a significant level of distress is identified, offer further assessment or seek the advice of a specialist (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

*The Distress Thermometer is a single-item question screen that will identify distress coming from any source. The person places a mark on the scale answering: 'How distressed have you been during the past week on a scale of 0 to 10?' Scores of 4 or more indicate a significant level of distress that should be investigated further.

Assessment

If the identification questions indicate a possible common mental health disorder, but the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate healthcare professional. If this professional is not the person's GP, inform the GP of the referral (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

If the identification questions indicate a possible common mental health disorder, a practitioner who is competent to perform a mental health assessment should review the person's mental state and associated functional, interpersonal, and social difficulties (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

When assessing a person with a suspected common mental health disorder, consider using:

- A diagnostic or problem identification tool or algorithm, for example, the Improving Access to Psychological Therapies (IAPT) screening prompts tool*
- A validated measure relevant to the disorder or problem being assessed, for example, the 9-item Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale (HADS) or the 7-item Generalized Anxiety Disorder scale (GAD-7) to inform the assessment and support the evaluation of any intervention

*For further information see 'The IAPT Data Handbook' Appendix C: IAPT Provisional Diagnosis Screening Prompts. Available from

All staff carrying out the assessment of suspected common mental health disorders should be competent to perform an assessment of the presenting problem in line with the service setting in which they work, and be able to:

- Determine the nature, duration, and severity of the presenting disorder
- Take into account not only symptom severity but also the associated functional impairment
- Identify appropriate treatment and referral options in line with relevant NICE guidance

All staff carrying out the assessment of common mental health disorders should be competent in:

- Relevant verbal and non-verbal communication skills, including the ability to elicit problems, the perception of the problem(s) and their impact, tailoring information, supporting participation in decision-making, and discussing treatment options
- The use of formal assessment measures and routine outcome measures in a variety of settings and environments

In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course, and severity of a person's presenting problem:

- A history of any mental health disorder
- A history of a chronic physical health problem
- Any past experience of, and response to, treatments
- The quality of interpersonal relationships
- Living conditions and social isolation
- A family history of mental illness
- A history of domestic violence or sexual abuse
- Employment and immigration status

If appropriate, the impact of the presenting problem on the care of children and young people should also be assessed, and if necessary local safeguarding procedures followed (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

When assessing a person with a suspected common mental health disorder, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

If the presentation and history of a common mental health disorder suggest that it may be mild and self-limiting (that is, symptoms are improving) and the disorder is of recent onset, consider providing psychoeducation and active monitoring before offering or referring for further assessment or treatment. These approaches may improve less severe presentations and avoid the need for further interventions.

Always ask people with a common mental health disorder directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:

- Assess whether the person has adequate social support and is aware of sources of help
- Arrange help appropriate to the level of risk advise the person to seek further help if the situation deteriorates (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

Antenatal and Postnatal Mental Health

During pregnancy or the postnatal period, women requiring psychological interventions should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological interventions during pregnancy and the postnatal period arising from the changing risk-benefit ratio for psychotropic medication at this time (adapted from [Antenatal and postnatal mental health](#) [NICE clinical guideline 45]).

When considering drug treatments for common mental health disorders in women who are pregnant, breastfeeding, or planning a pregnancy, consult [Antenatal and postnatal mental health](#) (NICE clinical guideline 45) for advice on prescribing.

Risk Assessment and Monitoring

If a person with a common mental health disorder presents a high risk of suicide or potential harm to others, a risk of significant self-neglect, or severe functional impairment, assess and manage the immediate problem first and then refer to specialist services. Where appropriate inform

families and carers.

If a person with a common mental health disorder presents considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services (adapted from [Depression. The treatment and management of depression in adults](#)

[NICE clinical guideline 90]).

If a person with a common mental health disorder, in particular depression, is assessed to be at risk of suicide:

- Take into account toxicity in overdose, if a drug is prescribed, and potential interaction with other prescribed medication; if necessary, limit the amount of drug(s) available
- Consider increasing the level of support, such as more frequent direct or telephone contacts
- Consider referral to specialist mental health services (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

Steps 2 and 3: Treatment and Referral for Treatment

The recommendations for treatment and referral are also presented in table form organised by disorder in Appendix F of the original guideline document.

Identifying the Correct Treatment Options

When discussing treatment options with a person with a common mental health disorder, consider:

- Their past experience of the disorder
- Their experience of, and response to, previous treatment
- The trajectory of symptoms
- The diagnosis or problem specification, severity, and duration of the problem
- The extent of any associated functional impairment arising from the disorder itself or any chronic physical health problem
- The presence of any social or personal factors that may have a role in the development or maintenance of the disorder
- The presence of any comorbid disorders

When discussing treatment options with a person with a common mental health disorder, provide information about:

- The nature, content, and duration of any proposed intervention
- The acceptability and tolerability of any proposed intervention
- Possible interactions with any current interventions
- The implications for the continuing provision of any current interventions

When making a referral for the treatment of a common mental health disorder, take account of patient preference when choosing from a range of evidence-based treatments.

When offering treatment for a common mental health disorder or making a referral, follow the stepped-care approach, usually offering or referring for the least intrusive, most effective intervention first (see Figure 1 in the original guideline document).

When a person presents with symptoms of anxiety and depression, assess the nature and extent of the symptoms, and if the person has:

- Depression that is accompanied by symptoms of anxiety, the first priority should usually be to treat the depressive disorder, in line with NICE guideline on depression
- An anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guidelines for the relevant anxiety disorder and consider treating the anxiety disorder first
- Both anxiety and depressive symptoms, with no formal diagnosis, that are associated with functional impairment, discuss with the person the symptoms to treat first and the choice of intervention (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

When a person presents with a common mental health disorder and harmful drinking or alcohol dependence, refer them for treatment of the alcohol misuse first as this may lead to significant improvement in depressive or anxiety symptoms (adapted from [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) [NICE clinical guideline 115]; see the NGC summary).

When a person presents with a common mental health disorder and a mild learning disability or mild cognitive impairment:

- Where possible provide or refer for the same interventions as for other people with the same common mental health disorder
- If providing interventions, adjust the method of delivery or duration of the assessment or intervention to take account of the disability or impairment (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

When a person presents with a common mental health disorder and has a moderate to severe learning disability or a moderate to severe cognitive impairment, consult a specialist concerning appropriate referral and treatment options.

Do not routinely vary the treatment strategies and referral practice for common mental health disorders described in this guideline either by personal characteristics (for example, sex or ethnicity) or by depression subtype (for example, atypical depression or seasonal depression) as there is no convincing evidence to support such action (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

If a person with a common mental health disorder needs social, educational, or vocational support, consider:

- Informing them about self-help groups (but not for people with post-traumatic stress disorder [PTSD]), support groups, and other local and national resources
- Befriending or a rehabilitation programme for people with long-standing moderate or severe disorders
- Educational and employment support services (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90]).

Step 2: Treatment and Referral Advice for Subthreshold Symptoms and Mild to Moderate Common Mental Health Disorders

For people with persistent subthreshold depressive symptoms or mild to moderate depression, offer or refer for one or more of the following low-intensity interventions:

- Individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- Computerised CBT
- A structured group physical activity programme
- A group-based peer support (self-help) programme (for those who also have a chronic physical health problem)
- Non-directive counselling delivered at home (listening visits) (for women during pregnancy or the postnatal period (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90], [Depression in adults with a chronic physical health problem](#) [NICE clinical guideline 91], and [Antenatal and postnatal mental health](#) [NICE clinical guideline 45]).

For pregnant women who have subthreshold symptoms of depression and/or anxiety that significantly interfere with personal and social functioning, consider providing or referring for:

- Individual brief psychological treatment (four to six sessions), such as interpersonal therapy (IPT) or CBT for women who have had a previous episode of depression or anxiety
- Social support during pregnancy and the postnatal period for women who have not had a previous episode of depression or anxiety; such support may consist of regular informal individual or group-based support (adapted from [Antenatal and postnatal mental health](#) [NICE clinical guideline 45]).

Do not offer antidepressants routinely for people with persistent subthreshold depressive symptoms or mild depression, but consider them for, or refer for an assessment, people with:

- Initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) or
- Subthreshold depressive symptoms or mild depression that persist(s) after other interventions or
- A past history of moderate or severe depression or
- Mild depression that complicates the care of a physical health problem (adapted from [Depression. The treatment and management of depression in adults](#) [NICE clinical guideline 90] and [Depression in adults with a chronic physical health problem](#) [NICE clinical guideline 91]).

For people with generalised anxiety disorder that has not improved after psychoeducation and active monitoring, offer or refer for one of the following low-intensity interventions:

- Individual non-facilitated self-help

- Individual facilitated self-help
- Psychoeducational groups (adapted from [Generalised anxiety disorder and panic disorder \[with or without agoraphobia\] in adults](#) [NICE clinical guideline 113]; see the NGC summary).

For people with mild to moderate panic disorder, offer or refer for one of the following low-intensity interventions:

- Individual non-facilitated self-help
- Individual facilitated self-help

For people with mild to moderate obsessive compulsive disorder (OCD):

- Offer or refer for individual CBT including exposure and response prevention (ERP) of limited duration (typically up to 10 hours), which could be provided using self-help materials or by telephone or
- Refer for group CBT (including ERP) (note, group formats may deliver more than 10 hours of therapy) (adapted from [Obsessive-compulsive disorder](#) [] [NICE clinical guideline 31]).

For people with PTSD, including those with mild to moderate PTSD, refer for a formal psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) (adapted from [Post-traumatic stress disorder](#) [] [NICE clinical guideline 26]).

Step 3: Treatment and Referral Advice for Persistent Subthreshold Depressive Symptoms or Mild to Moderate Common Mental Health Disorders with Inadequate Response to Initial Interventions, or Moderate to Severe Common Mental Health Disorders

If there has been an inadequate response following the delivery of a first-line treatment for persistent subthreshold depressive symptoms or mild to moderate common mental health disorders, a range of psychological, pharmacological, or combined interventions may be considered. This section also recommends interventions or provides referral advice for first presentation of moderate to severe common mental health disorders.

For people with persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention, offer or refer for:

- Antidepressant medication or
- A psychological intervention (CBT, IPT, behavioural activation, or behavioural couples therapy) (adapted from [Depression. The treatment and management of depression in adults](#) [] [NICE clinical guideline 90]).

For people with an initial presentation of moderate or severe depression, offer or refer for a psychological intervention (CBT or IPT) in combination with an antidepressant (adapted from [Depression. The treatment and management of depression in adults](#) [] [NICE clinical guideline 90]).

For people with moderate to severe depression and a chronic physical health problem consider referral to collaborative care if there has been no, or only a limited, response to psychological or drug treatment alone or combined in the current or in a past episode (adapted from [Depression in adults with a chronic physical health problem](#) [] [NICE clinical guideline 91]).

For people with depression who decline an antidepressant, CBT, IPT, behavioural activation, and behavioural couples therapy, consider providing or referring for:

- Counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression
- Short-term psychodynamic psychotherapy for people with mild to moderate depression

Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression (adapted from [Depression in adults with a chronic physical health problem](#) [] [NICE clinical guideline 91]).

For people with generalised anxiety disorder who have marked functional impairment or have not responded to a low-intensity intervention, offer or refer for one of the following:

- CBT or
- Applied relaxation or
- If the person prefers, drug treatment (adapted from [Generalised anxiety disorder and panic disorder \[with or without agoraphobia\] in adults](#) [NICE clinical guideline 113]; see the NGC summary).

For people with moderate to severe panic disorder (with or without agoraphobia), consider referral for:

- CBT or
- An antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological interventions (adapted from [Generalised anxiety disorder and panic disorder \[with or without agoraphobia\] in adults](#) [NICE clinical guideline 113]; see the NGC summary).

For people with OCD and moderate or severe functional impairment, and in particular where there is significant comorbidity with other common mental health disorders, offer or refer for:

- CBT (including ERP) or antidepressant medication for moderate impairment
- CBT (including ERP) combined with antidepressant medication and case management for severe impairment

Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding) (adapted from [Obsessive-compulsive disorder](#) [] [NICE clinical guideline 31]).

For people with long-standing OCD or with symptoms that are severely disabling and restrict their life, consider referral to a specialist mental health service (adapted from [Obsessive-compulsive disorder](#) [] [NICE clinical guideline 31]).

For people with OCD who have not benefitted from two courses of CBT (including ERP) combined with antidepressant medication, refer to a service with specialist expertise in OCD (adapted from [Obsessive-compulsive disorder](#) [] [NICE clinical guideline 31]).

For people with PTSD, offer or refer for a psychological intervention (trauma-focused CBT or EMDR). Do not delay the intervention or referral, particularly for people with severe and escalating symptoms in the first month after the traumatic event (adapted from [Post-traumatic stress disorder](#) [] [NICE clinical guideline 26]).

For people with PTSD, offer or refer for drug treatment only if a person declines an offer of a psychological intervention or expresses a preference for drug treatment (adapted from [Post-traumatic stress disorder](#) [] [NICE clinical guideline 26]).

Treatment and Referral Advice to Help Prevent Relapse

For people with a common mental health disorder who are at significant risk of relapse or have a history of recurrent problems, discuss with the person the treatments that might reduce the risk of recurrence. The choice of treatment or referral for treatment should be informed by the response to previous treatment, including residual symptoms, the consequences of relapse, any discontinuation symptoms when stopping medication, and the person's preference.

For people with a previous history of depression who are currently well and who are considered at risk of relapse despite taking antidepressant medication, or those who are unable to continue or choose not to continue antidepressant medication, offer or refer for one of the following:

- Individual CBT
- Mindfulness-based cognitive therapy (for those who have had three or more episodes) (adapted from [Depression. The treatment and management of depression in adults](#) [] [NICE clinical guideline 90] and [Depression in adults with a chronic physical health problem](#) [] [NICE clinical guideline 91; see the NGC summary]).

For people who have had previous treatment for depression but continue to have residual depressive symptoms, offer or refer for one of the following:

- Individual CBT
- Mindfulness-based cognitive therapy (for those who have had three or more episodes) (adapted from [Depression. The treatment and management of depression in adults](#) [] [NICE clinical guideline 90]).

Developing Local Care Pathways

Local care pathways should be developed to promote implementation of key principles of good care. Pathways should be:

- Negotiable, workable, and understandable for people with common mental health disorders, their families and carers, and professionals
- Accessible and acceptable to all people in need of the services served by the pathway
- Responsive to the needs of people with common mental health disorders and their families and carers
- Integrated so that there are no barriers to movement between different levels of the pathway
- Outcomes focused (including measures of quality, service-user experience, and harm)

Responsibility for the development, management, and evaluation of local care pathways should lie with a designated leadership team, which should include primary and secondary care clinicians, managers, and commissioners. The leadership team should have particular responsibility for:

- Developing clear policy and protocols for the operation of the pathway
- Providing training and support on the operation of the pathway
- Auditing and reviewing the performance of the pathway

Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that promote a stepped-care model of service delivery that:

- Provides the least intrusive, most effective intervention first
- Has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- Does not use single criteria such as symptom severity to determine movement between steps
- Monitors progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed

Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that promote a range of evidence-based interventions at each step in the pathway and support people with common mental health disorders in their choice of interventions.

All staff should ensure effective engagement with families and carers, where appropriate, to:

- Inform and improve the care of the person with a common mental health disorder
- Meet the identified needs of the families and carers

Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that promote the active engagement of all populations served by the pathway. Pathways should:

- Offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age, and communication needs of people with common mental health disorders
- Keep to a minimum the number of assessments needed to access interventions

Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that respond promptly and effectively to the changing needs of all populations served by the pathways. Pathways should have in place:

- Clear and agreed goals for the services offered to a person with a common mental health disorder
- Robust and effective means for measuring and evaluating the outcomes associated with the agreed goals
- Clear and agreed mechanisms for responding promptly to identified changes to the person's needs

Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that provide an integrated programme of care across both primary and secondary care services. Pathways should:

- Minimise the need for transition between different services or providers
- Allow services to be built around the pathway and not the pathway around the services
- Establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- Have designated staff who are responsible for the coordination of people's engagement with the pathway

Primary and secondary care clinicians, managers, and commissioners should work together to ensure effective communication about the functioning of the local care pathway. There should be protocols for:

- Sharing and communicating information with people with common mental health disorders, and where appropriate families and carers, about their care
- Sharing and communicating information about the care of service users with other professionals (including GPs)
- Communicating information between the services provided within the pathway
- Communicating information to services outside the pathway

Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that have robust systems for outcome measurement in place, which should be used to inform all involved in a pathway about its effectiveness. This should include providing:

- Individual routine outcome measurement systems
- Effective electronic systems for the routine reporting and aggregation of outcome measures
- Effective systems for the audit and review of the overall clinical and cost-effectiveness of the pathway

Clinical Algorithm(s)

The quick reference guide (available from www.nice.org.uk/guidance/CG123/QuickRefGuide ; see also the "Availability of Companion Documents" field) contains a stepped-care model for common mental health disorders and an algorithm for the identification and assessment of common mental health disorders.

Scope

Disease/Condition(s)

Depression

Other Disease/Condition(s) Addressed

- Generalized anxiety disorder
- Obsessive compulsive disorder
- Panic disorder
- Post-traumatic stress disorder
- Social anxiety

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Guideline Objective(s)

- To review aspects of service delivery critical to the effective provision of clinical interventions for common mental health disorders
- To review aspects of service delivery critical to effective implementation of existing National Institute for Health and Clinical Excellence (NICE) guidelines covering these disorders
- To evaluate models of service delivery designed to promote access to services
- To evaluate the role of methods for identification and assessment
- To develop treatment and referral advice for common mental health disorders through adaptation and adoption of recommendations from existing NICE guidelines
- To evaluate the role of systems for organising and developing local care pathways for these disorders
- To consider the experience of care from the perspective of people with a common mental health disorder, and their families and carers
- To promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service (NHS) in England and Wales.

Target Population

Adults (18 years and older) with common mental health disorders, that is:

- Depression (including subthreshold disorders)
- Anxiety disorders (including generalised anxiety disorder, panic disorder, social anxiety, obsessive compulsive disorder, and post-traumatic stress disorder)
- Comorbid presentations of anxiety and depression

Note: The following groups will not be covered:

Adults with:

- Subthreshold mixed anxiety and depression
- Psychotic and related disorders (including schizophrenia and bipolar disorder)
- Those for whom drug and alcohol misuse are the primary problem
- Those for whom eating disorders are the primary problem
- Children and people younger than 18 years old

Interventions and Practices Considered

Assessment/Evaluation

1. Identification of patients with depression and anxiety disorders
2. Mental health assessment
3. Risk assessment and monitoring
4. Diagnostic or problem identification tool or algorithm (Improving Access to Psychological Therapies [IAPT] screening prompts tool)
5. Validated measure relevant to the disorder or problem being assessed (9-item Patient Health Questionnaire [PHQ-9], the Hospital Anxiety and Depression Scale [HADS] or the 7-item Generalized Anxiety Disorder scale [GAD-7])

6. Staff competency in performing assessments, communication skills
7. Awareness of patient's learning disorders or acquired cognitive impairments
8. Consultation with relevant specialist as indicated
9. Determine risk of suicide or self harm

Management/Treatment

1. Stepped care model
2. Accounting for patient preference
3. Referral for alcohol misuse, as indicated
4. Arranging help appropriate for level of risk of self harm or suicide
5. Antenatal and postnatal psychological interventions
6. Management of patients with common mental health disorders and learning disability or cognitive impairment
7. Cognitive behavioural therapy, including exposure and response prevention
8. Structured group physical activity programmes
9. Peer support (self-help) programmes
10. Non-directive counselling (listening visits)
11. Interpersonal therapy
12. Antidepressants
13. Other interventions (individual facilitated or non-facilitated self-help, psychoeducational groups, eye movement desensitisation and reprocessing, behavioural activation, behavioural couples therapy, psychodynamic psychotherapy), as indicated
14. Referral to specialist mental health service
15. Prevention of relapse
16. Provision of information to patients, their families and carers
17. Organisation and planning of service
 - Development of local care pathways
 - Provision of information
 - Support for access to services

Major Outcomes Considered

- Factors affecting access to health care
- Proportion of people from the target group who access treatment
- Uptake of treatment
- Treatment satisfaction and preference
- Anxiety about treatment
- Individual/practitioner communication
- Sensitivity, specificity, positive predictive value, negative predictive value, and area under the curve of case identification tools
- Clinical utility of formal assessments and risk assessment
- Association between predictor of treatment response and treatment response/failure
- Common mental health disorder symptoms
- Duration of treatment
- Adequacy of treatment
- Functional status
- Quality of life
- Cost effectiveness (quality-adjusted life years)

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Systematic Clinical Literature Review

The aim of the clinical literature review was to systematically identify and synthesise relevant evidence from the literature in order to answer the specific review questions developed by the guideline development group (GDG).

Methodology

A stepwise, hierarchical approach was taken to locating and presenting evidence to the GDG. NCCMH developed this process based on methods set out by the National Institute of Health and Clinical Excellence (NICE) (The Guidelines Manual, 2009), and after considering recommendations from a range of other sources. These included:

- Clinical Policy and Practice Program of the New South Wales Department of Health (Australia)
- British Medical Journal (BMJ) Clinical Evidence
- Grading of Recommendations: Assessment, Development, and Evaluation (GRADE) Working Group
- New Zealand Guidelines Group
- National Health Service (NHS) Centre for Reviews and Dissemination
- Oxford Centre for Evidence-Based Medicine
- Oxford Systematic Review Development Programme
- Scottish Intercollegiate Guidelines Network (SIGN)
- The Cochrane Collaboration
- United States Agency for Healthcare Research and Quality

The Review Process

Scoping Searches

A broad preliminary search of the literature was undertaken in October 2009 to obtain an overview of the issues likely to be covered by the scope, and to help define key areas. Searches were restricted to clinical guidelines, health technology assessment reports, key systematic reviews and randomised controlled trials (RCTs). See Section 3.5.2 in the full version of the guideline document for databases and websites searched.

Existing NICE guidelines were updated where necessary. Other relevant guidelines were assessed for quality using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument. Where an individual review from another guideline was used (rather than the full guideline), the systematic review methodology checklist was used, rather than the AGREE instrument. The evidence base underlying high-quality existing guidelines was utilised and updated as appropriate. Further information about this process can be found in The Guidelines Manual (2009).

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching, to identify as complete a set as possible of clinically relevant studies.

Searches were conducted in the following databases:

- CINAHL
- EMBASE
- Medline/Medline In-Process
- PsycINFO

- CENTRAL
- CDSR
- DARE

The search strategies were initially developed for Medline before being translated for use in other databases/interfaces. Strategies were built up from a number of trial searches, and discussions of the results of the searches with the review team/GDG, to ensure that all possible relevant search terms were covered.

See Section 3.5 in the full version of the original guideline for additional information about use of Reference Manager, search filters, date and language restrictions, post-guideline searching, and other search methods. Full details of the Medline search strategies/filters used for the systematic review of clinical evidence are provided in Appendix 6 in the full version of the original guideline document.

Study Selection and Quality Assessment

All studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into Review Manager or evidence tables. More specific eligibility criteria were developed for each review question and are described in the relevant clinical evidence chapters in the full version of the original guideline document. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (see Appendix 7 in the full version of the original guideline document for methodology checklists). The eligibility of each study was confirmed by at least one member of the appropriate topic group.

For some review questions, it was necessary to prioritise the evidence with respect to the UK context (that is, external validity). To make this process explicit, the GDG took into account the following factors when assessing the evidence:

- Participant factors (for example, gender, age and ethnicity)
- Provider factors (for example, model fidelity, the conditions under which the intervention was performed and the availability of experienced staff to undertake the procedure)
- Cultural factors (for example, differences in standard care and differences in the welfare system)

It was the responsibility of each topic group to decide which prioritisation factors were relevant to each review question in light of the UK context and then decide how they should modify their recommendations.

Unpublished Evidence

The GDG used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must have been accompanied by a trial report containing sufficient detail to properly assess the quality of the data. Second, the evidence must have been submitted with the understanding that data from the study and a summary of the study's characteristics would be published in the full guideline. Therefore, the GDG did not accept evidence submitted as commercial in confidence. However, the GDG recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their research.

Health Economics Methods

Search Strategy for Economic Evidence

Scoping Searches

A broad preliminary search of the literature was undertaken in October 2009 to obtain an overview of the issues likely to be covered by the scope, and help define key areas. Searches were restricted to economic studies and health technology assessment reports. Any relevant economic evidence arising from the clinical scoping searches was also made available to the health economist during the same period. See Section 3.6.1 in the full version of the original guideline document for more detail.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching to maximise retrieval performance. Searches were restricted to economic evidence (including full and partial economic evaluations) and health technology assessment reports, and conducted in the following databases:

- EconLit
- EMBASE
- MEDLINE/MEDLINE In-Process

- PsycINFO
- Health Technology Assessment (HTA) database (technology assessments)
- NHS EED

Any relevant economic evidence arising from the clinical searches was also made available to the health economist during the same period.

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches, and discussions of the results of the searches with the review team/GDG, to ensure that all possible relevant search terms were covered.

See Section 3.6 in the full version of the original guideline for additional information about use of Reference Manager, search filters, date and language restrictions, and other search methods. Full details of the Medline search strategies/filters used for the systematic review of clinical evidence are provided in Appendix 6 in the full version of the original guideline document. Full details of the search strategies and filter used for the systematic review of health economic evidence are provided in Appendix 8 in the full version of the original guideline document.

Inclusion Criteria for Economic Studies

See Section 3.6.2 in the full version of the original guideline document for inclusion criteria for economic studies.

Applicability and Quality Criteria for Economic Studies

All economic papers eligible for inclusion were appraised for their applicability and quality using the methodology checklist for economic evaluations recommended by the NICE Guidelines Manual 2009, which is shown in Appendix 9 in the full version of the original guideline document. The methodology checklist for economic evaluations was also applied to the economic models developed specifically for this guideline. All studies that fully or partially met the applicability and quality criteria described in the methodology checklist were considered during the guideline development process, along with the results of the economic modelling conducted specifically for this guideline. The completed methodology checklists for all economic evaluations considered in the guideline are provided in Appendix 12 in the full version of the original guideline document.

Results of the Systematic Search of Economic Literature

The titles of all studies identified by the systematic search of the literature were screened for their relevance to the topic (i.e., economic issues and information on health-related quality of life in people with common mental health disorders). References that were clearly not relevant were excluded first. The abstracts of all potentially relevant studies (235 references) were then assessed against the inclusion criteria for economic evaluations by the health economist. Full texts of the studies potentially meeting the inclusion criteria (including those for which eligibility was not clear from the abstract) were obtained. Studies that did not meet the inclusion criteria, were duplicates, were secondary publications of one study, or had been updated in more recent publications were subsequently excluded. Economic evaluations eligible for inclusion (that is, one study on stepped care and one study on identification methods) were then appraised for their applicability and quality using the methodology checklist for economic evaluations. Of these, one economic study met, fully or partially, the applicability and quality criteria and was considered at formulation of the guideline recommendations.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Not Given)

Rating Scheme for the Strength of the Evidence

Not stated

Methods Used to Analyze the Evidence

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Data Extraction

Study characteristics and outcome data were extracted from all eligible studies, which met the minimum quality criteria, using Review Manager 5 (The Cochrane Collaboration, 2008) or word-based evidence tables. See Section 3.5.3 in the full version of the original guideline document for more detail.

Evidence Synthesis and Presentation

Existing Guidelines and Systematic Reviews

Existing NICE guidelines (listed in Section 2.1 in the full version of the original guideline document) provided an important relevant source of evidence for the development of this guideline in terms of treatment and referral advice for common mental health disorders, and this was subject to narrative synthesis.

Methods for conducting narrative synthesis were used to synthesise existing NICE guidelines relevant to common mental health disorders, and systematic reviews identified during the literature search. In most cases, a preliminary synthesis was made using tabulation. This was then used to write an evidence summary.

Meta-analysis of Diagnostic Accuracy Data

Review Manager 5 was used to summarise diagnostic accuracy data from each study using forest plots and summary receiver operating characteristic (ROC) plots. Where more than two studies reported appropriate data, a bivariate diagnostic accuracy meta-analysis was conducted using Stata 10 with the MIDAS (Module for Meta-analytical Integration of Diagnostic Test Accuracy Studies) command in order to obtain pooled estimates of sensitivity, specificity, likelihood ratios, and diagnostic odds ratio (OR). See Section 3.5.4 in the full version of the original guideline document for more detail.

Health Economic Methods

The aim of the health economics was to contribute to the guideline's development by providing evidence on the cost effectiveness of interventions for common mental health disorders covered in the guideline. This was achieved by:

- Systematic literature review of existing economic evidence
- Decision-analytic economic modelling

Systematic reviews of economic literature were conducted in all areas covered in the guideline. Economic modelling was undertaken in areas with likely major resource implications, where available clinical evidence was sufficient to allow the development of an economic model that would provide fairly robust evidence on the cost effectiveness of interventions for the management of people with common mental health disorders. Prioritisation of areas for economic modelling was a joint decision between the health economist and the GDG. After considering areas with potentially significant resource implications and the availability of respective clinical data, the following economic question was selected as a key issue that was addressed by economic modelling:

- Cost effectiveness of case identification for people with common mental health disorders.

In addition, literature on the health-related quality of life (HRQoL) of people with common mental health disorders, especially anxiety and depression, was systematically searched to identify studies reporting appropriate utility scores that could be utilised in a cost-utility analysis.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Review Questions

Review (clinical) questions were used to guide the identification and interrogation of the evidence base relevant to the topic of the guideline. Before the first Guideline Development Group (GDG) meeting, an analytic framework (see Appendix 4 in the full version of the original guideline) was prepared by NCCMH staff based on the scope and an overview of existing guidelines, and discussed with the guideline Chair. The framework was used to provide a structure from which the review questions were drafted. Both the analytic framework and the draft review questions were then discussed by the GDG at the first few meetings and amended as necessary. Where appropriate, the framework and questions were refined once the evidence had been searched and, where necessary, sub-questions were generated. Questions submitted by stakeholders were also discussed by the GDG and the rationale for not including any questions was recorded in the minutes. The final list of review questions can be found in Appendix 4 in the full version of the original guideline.

The GDG

The GDG consisted of professionals in psychiatry, clinical psychology, nursing, and general practice; academic experts in psychiatry and psychology; two people with a common mental health disorder and a carer. The guideline development process was supported by staff from the NCCMH, who undertook the clinical and health economics literature searches, reviewed and presented the evidence to the GDG, managed the process, and contributed to drafting the guideline.

GDG Meetings

Nine GDG meetings were held between December 2009 and January 2011. During each day-long GDG meeting review questions and clinical and economic evidence were reviewed and assessed, and recommendations formulated. At each meeting, all GDG members declared any potential conflicts of interest, and service user and carer concerns were routinely discussed as part of a standing agenda.

Topic Groups

The GDG divided its workload along clinically relevant lines to simplify the guideline development process, and GDG members formed smaller topic groups to undertake guideline work in that area of clinical practice. Topic Group 1 covered questions relating to access to healthcare. Topic Group 2 covered case identification, Topic Group 3 covered assessment, and Topic Group 4 covered systems for organising and developing local care pathways. These groups were designed to efficiently manage the large volume of evidence appraisal prior to presenting it to the GDG as a whole. Each topic group was chaired by a GDG member with expert knowledge of the topic area (one of the healthcare professionals). Topic groups were responsible for refining the review questions relevant to the topic, and assisted with the review and synthesis of the evidence. All decisions concerning recommendations were made by the full GDG. Topic group leaders reported the status of the group's work as part of the standing agenda. They also introduced and led the GDG discussion of the evidence review for that topic and assisted the technical staff from the NCCMH in drafting the section of the guideline relevant to the work of each topic group.

Service Users and Carers

Individuals with direct experience of services gave an integral service-user focus to the GDG and the guideline. The GDG included two people with a common mental health disorder and a carer. They contributed as full GDG members to writing the review questions, helping to ensure that the evidence addressed their views and preferences, highlighting sensitive issues and terminology relevant to the guideline, and bringing service-user research to the attention of the GDG. In drafting the guideline, they contributed to developing the evidence chapters and identified recommendations from the service user and carer perspective.

From Evidence to Recommendations

Once the clinical and health economic evidence was summarised, the GDG drafted the recommendations. The GDG took account of the principles

of stepped-care approaches when considering the evidence and formulating recommendations.

In making recommendations, the GDG took into account the trade-off between the benefits and downsides of the intervention/instrument, as well as other important factors, such as economic considerations, values of the development group and society, the requirements to prevent discrimination and to promote equality, and the group's awareness of practical issues.

Finally, to show clearly how the GDG moved from the evidence to the recommendations, each chapter has a section called 'from evidence to recommendations'. Underpinning this section is the concept of the 'strength' of a recommendation. This takes into account the quality of the evidence but is conceptually different. Some recommendations are 'strong' in that the GDG believes that the vast majority of healthcare professionals and patients would choose a particular intervention if they considered the evidence in the same way that the GDG has. This is generally the case if the benefits clearly outweigh the harms for most people and the intervention is likely to be cost effective. However, there is often a closer balance between benefits and harms, and some patients would not choose an intervention whereas others would. This may happen, for example, if some service users are particularly averse to some side effect and others are not. In these circumstances the recommendation is generally weaker, although it may be possible to make stronger recommendations about specific groups of patients. The strength of each recommendation is reflected in the wording of the recommendation, rather than by using ratings, labels, or symbols.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

Presentation of Economic Evidence

The economic evidence considered in the guideline is provided in the respective evidence chapters in the full version of the original guideline document, following presentation of the relevant clinical evidence. The references to included studies and the respective evidence tables with the study characteristics and results are provided in Appendix 10 in the full version of original guideline document. Methods and results of economic modelling undertaken alongside the guideline development process are presented in the relevant evidence chapters in the full version of the original guideline document.

Case Identification and Formal Assessment

Existing economic evidence is particularly limited in the area of identification methods for people with common mental health disorders. The economic analysis undertaken for this guideline suggests that the use of formal identification tools (generalised anxiety disorder-2 [GAD-2] followed by GAD-7) comprises a cost-effective option when compared to GP assessment alone (without using formal identification tools) for people with GAD (as a proxy for the anxiety disorders), as it appears to result in better outcomes (more people identified and higher number of quality-adjusted life years [QALYs]) and lower total costs. See Section 5.2.9 in the full version of the original guideline document for details of the cost analysis.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Registered stakeholders had an opportunity to comment on the draft guideline, which was posted on the National Institute for Health and Clinical Excellence (NICE) website during the consultation period. Following the consultation, all comments from stakeholders and others were responded to, and the guideline updated as appropriate. The Guideline Review Panel (GRP) also reviewed the guideline and checked that stakeholders' comments had been addressed.

Following the consultation period, the Guideline Development Group (GDG) finalised the recommendations and the NCCMH produced the final documents. These were then submitted to NICE for the pre-publication check where stakeholders were given the opportunity to highlight factual

errors. Any errors were corrected by the National Collaborating Centre for Mental Health (NCCMH), then the guideline was formally approved by NICE and issued as guidance to the National Health Service (NHS) in England and Wales.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

Clinical practice recommendations are evidence-based, where possible, and, if evidence was not available, informal consensus methods were used.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate identification and care of common mental health disorders

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Implementation of the Guideline

Description of Implementation Strategy

National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance. These are available on the NICE Web site (<http://guidance.nice.org.uk/CG123> ; see also the "Availability of Companion Documents" field).

Key Priorities for Implementation

Improving Access to Services

Primary and secondary care clinicians, managers, and commissioners should collaborate to develop local care pathways (see also Section 1.5 of the original guideline document) that promote access to services for people with common mental health disorders by:

Supporting the integrated delivery of services across primary and secondary care

Having clear and explicit criteria for entry to the service

Focusing on entry and not exclusion criteria

Having multiple means (including self-referral) to access the service

Providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located

Identification

- Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression, or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:
 - During the last month, have you often been bothered by feeling down, depressed, or hopeless?
 - During the last month, have you often been bothered by having little interest or pleasure in doing things?If a person answers 'yes' to either of the above questions consider depression and follow the recommendations for assessment (see Section 1.3.2 of the original guideline document).
- Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see Appendix D in the original guideline document).
 - If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see Section 1.3.2 of the original guideline document).
 - If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and follow the recommendations for assessment (see Section 1.3.2 of the original guideline document).

Developing Local Care Pathways

- Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that promote a stepped-care model of service delivery that:
 - Provides the least intrusive, most effective intervention first
 - Has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
 - Does not use single criteria such as symptom severity to determine movement between steps
 - Monitors progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed
- Primary and secondary care clinicians, managers, and commissioners should work together to design local care pathways that provide an integrated programme of care across both primary and secondary care services. Pathways should:
 - Minimise the need for transition between different services or providers
 - Allow services to be built around the pathway and not the pathway around the services
 - Establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
 - Have designated staff who are responsible for the coordination of people's engagement with the pathway
- Primary and secondary care clinicians, managers, and commissioners should work together to ensure effective communication about the functioning of the local care pathway. There should be protocols for:
 - Sharing and communicating information with people with common mental health disorders, and where appropriate families and carers, about their care
 - Sharing and communicating information about the care of service users with other professionals (including general practitioners [GPs])
 - Communicating information between the services provided within the pathway
 - Communicating information to services outside the pathway

Implementation Tools

Chart Documentation/Checklists/Forms

Clinical Algorithm

Foreign Language Translations

Patient Resources

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Common mental health disorders. Identification and pathways to care. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. 61 p. (Clinical guideline; no. 123).

Adaptation

Some recommendations in this guideline have been adapted from:

- National Collaborating Centre for Mental Health. Depression. The treatment and management of depression in adults. London (UK): National Institute for Health and Clinical Excellence (NICE); (Clinical guideline; no. 90) 2009 Oct.
- National Collaborating Centre for Mental Health. Antenatal and postnatal mental health. London (UK): National Institute for Health and Clinical Excellence (NICE); (Clinical guideline; no. 45) 2007 Apr.
- National Collaborating Centre for Mental Health. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. London (UK): National Institute for Health and Clinical Excellence (NICE); (Clinical guideline; no. 115) 2011 Feb.
- National Collaborating Centre for Mental Health and the National Collaborating Centre for Primary Care. Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. London (UK): National Institute for Health and Clinical Excellence (NICE); (Clinical guideline; no. 115) 2011 Jan.
- National Collaborating Centre for Mental Health. Obsessive-compulsive disorder. London (UK): National Institute for Health and Clinical Excellence (NICE); (Clinical guideline; no. 22) 2005 Nov.
- National Collaborating Centre for Mental Health. Post-traumatic stress disorder London (UK): National Institute for Health and Clinical Excellence (NICE); (Clinical guideline; no. 26) 2005 Mar.
- National Collaborating Centre for Mental Health. Depression in adults with a chronic physical health problem. Treatment and management.

Date Released

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Guideline Developer(s)

National Collaborating Centre for Mental Health - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Clinical Excellence (NICE)

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group Members: Professor Tony Kendrick (*Chair*), Professor of Primary Care and Dean, Hull York Medical School; General Practitioner, Hull Primary Care Trust; Professor Stephen Pilling (*Facilitator*), Director, National Collaborating Centre for Mental Health; Director, Centre for Outcomes Research and Effectiveness, University College London; Mr Mike Bessant, Mental Health Nurse, Regional Mental Health Lead, NHS Direct, Bristol; Ms Mary Burd, Head of Psychology and Counselling, Tower Hamlets Primary Care Trust (until December 2009); Dr Alan Cohen, Director of Primary Care, West London Mental Health Trust; National Primary Care Advisor, Improving Access to Psychological Therapies, Department of Health; Dr Barbara Compitus, General Practitioner, Southville, Bristol; Ms Lillian Dimas, Service user and carer member; Ms Beth Dumonteil, Project Manager 2009-2010, National Collaborating Centre for Mental Health; Mr David Ekers, Nurse Consultant, Primary Care Mental Health, Tees Esk and Wear Valleys NHS Foundation Trust; Honorary Clinical Lecturer, Centre for Mental Health Research, Durham University; Professor Linda Gask, Professor of Primary Care Psychiatry, University of Manchester; Honorary Consultant Psychiatrist, Salford Primary Care Trust; Ms Laura Gibbon, Project Manager 2010-2011, National Collaborating Centre for Mental Health; Professor Simon Gilbody, Professor of Psychological Medicine and Health Services, Hull York Medical School; Ms Flora Kaminski, Research Assistant, National Collaborating Centre for Mental Health; Dr Dinitra Lambrelli, Health Economist, National Collaborating Centre for Mental Health; Mr Terence Lewis, Service user and carer member; Mr Francesco Palma, Service user and carer member; Dr Matthew Ridd, General Practitioner, Portishead; Clinical Lecturer, National Institute for Health Research, Bristol; Ms Caroline Salter, Research Assistant, National Collaborating Centre for Mental Health; Ms Christine Sealey, Centre Manager, National Collaborating Centre for Mental Health; Ms Melinda Smith, Research Assistant, National Collaborating Centre for Mental Health; Professor Roz Shafran, Professor of Psychology, School of Psychology and Clinical Language Sciences, University of Reading; Ms Sarah Stockton, Senior Information Scientist, National Collaborating Centre for Mental Health; Mr Rupert Suckling, Deputy Director of Public Health and Consultant in Public Health Medicine, Doncaster Primary Care Trust; Dr Clare Taylor, Senior Editor, National Collaborating Centre for Mental Health; Dr Amina Yesufu-Udechuku, Systematic Reviewer, National Collaborating Centre for Mental Health; Dr Craig Whittington, Senior Systematic Reviewer, National Collaborating Centre for Mental Health

Financial Disclosures/Conflicts of Interest

At each meeting, all guideline development group members declared any potential conflicts of interest, and service user and carer concerns were routinely discussed as part of a standing agenda. See Appendix 2 in the full version of the original guideline document for a list of declarations.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#) .

Availability of Companion Documents

The following are available:

- Common mental health disorders. Identification and pathways to care. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. 24 p. (Clinical guideline; no. 123). Electronic copies: Available in Portable Document Format (PDF) from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#) .
- Common mental health disorders. The NICE guideline on identification and pathways to care. Full guideline. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. 312 p. (Clinical guideline; no. 123). Electronic copies: Available in PDF from the [NICE Web site](#) .
- Common mental health disorders. The NICE guideline on identification and pathways to care. Appendices. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. Various p. (Clinical guideline; no. 123). Electronic copies: Available in PDF from the [NICE Web site](#) .
- Common mental health disorders. Identification and pathways to care. Costing report. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. 25 p. (Clinical guideline; no. 123). Electronic copies: Available in PDF from the [NICE Web site](#) .
- Common mental health disorders. Identification and pathways to care. Costing template. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. (Clinical guideline; no. 123). Electronic copies: Available from the [NICE Web site](#) .
- Common mental health disorders. Baseline assessment tool. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. (Clinical guideline; no. 123). Electronic copies: Available from the [NICE Web site](#) .
- Common mental health disorders: identification and pathways to care. Slide set. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 May. 30 p. (Clinical guideline; no. 123). Electronic copies: Available from the [NICE Web site](#) .
- Guide for commissioners: commissioning stepped care for people with common mental health disorders. Available from the [NICE Web site](#) .
- Common mental health disorders. Podcast. Available from the [NICE Web site](#) .
- The guidelines manual 2009. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. Electronic copies: Available in PDF from the [NICE Archive Web site](#) .

In addition, the Generalized Anxiety Disorder (GAD) screening tools are available in Appendix D of the [original guideline document](#) .

Patient Resources

The following is available:

- Getting help and support for common mental health problems. Understanding NICE guidance. Information for people who use NHS services. London: National Institute for Health and Clinical Excellence (NICE); 2011 May. 26 p. Electronic copies: Available from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#) . Also available in Welsh from the [NICE Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This summary was completed by ECRI Institute on March 16, 2012.

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